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THE SELF-ASSESSMENT OF THE HEALTH CONDITION VERSUS PERSONAL RESOURCES AND HEALTH BEHAVIORS OF HOMELESS PEOPLE

Samoocena stanu zdrowia a zasoby osobiste i zachowania zdrowotne bezdomnych

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Abstract (in Polish):

Cel pracy

Celem pracy była analiza zależności między samooceną stanu zdrowia badanych osób bezdomnych a ich zasobami osobistymi oraz zachowaniami zdrowotnymi.

Materiał i metody

Badania przeprowadzono w okresie od listopada 2016 r. do marca 2017 r. w sześciu ośrodkach dla bezdomnych w Polsce. Do zebrania danych wykorzystano: oryginalne kwestionariusz autorski, profil zdrowia Nottingham (NHP), inwentarz zachowań zdrowotnych (IZZ), wielowymiarowe umiejscowienie kontroli zdrowia (MHLC) oraz ogólną skalę poczucia własnej skuteczności (GSES). Badania przeprowadzono wśród grupy 58 osób bezdomnych Analizę danych przeprowadzono metodą t-Studenta, test U Manna – Whitneya i korelację rho Spearmana. Poziom istotności został przyjęty jako równy p=0.005.

Wyniki
Osiągnięte wyniki wykazały, że osoby bezdomne oceniają swój stan zdrowia jako średni lub wskazując jakość lepszą niż średnia. Mimo to osoby te wskazują niższe wartości wskaźników zachowań zdrowotnych niż średnie wartości w grupie normalizacyjnej. Właściwe nawyki żywieniowe, zachowania profilaktyczne i korzystne dla zdrowia praktyki znacznie rzadziej dotyczą osób bezdomnych niż pozostałych osób. Bezdomni deklarują poczucie zewnętrznej kontroli nad swoim zdrowiem a także niskie poczucie skuteczności. Osoby z niskim poczuciem własnej skuteczności czuły się bardziej wyobcowane niż osoby z wysokim poczuciem własnej skuteczności.

Wnioski
Z punktu widzenia zdrowia osoby bezdomne wymagają profesjonalnej pomocy wielu przeszkolonych specjalistów, takich jak na przykład pielęgniarki. Istotne jest wzmacnianie poczucia skuteczności bezdomnych oraz kształtowanie pozytywnych nawyków zdrowotnych.

Abstract (in English):

Aim
The goal of the paper was to analyze the convergence between the self-assessment of health condition and personal resources as well as health behaviors of homeless people.

Material and methods
The research has been carried out between November 2016 and March 2017 in six centers for the homeless in Poland. The following have been used to collect data from a group of 58 homeless people: an original survey, Nottingham Health Profile (NHP), Health Behavior Inventory (IZZ), Multidimensional Health Locus of Control (MHLC), and General Self-Efficacy Scale (GSES). The data analysis has been carried out with the use of the t-Student method, Mann–Whitney U test, and Spearman's rho correlation. The level of significance has been accepted as $\alpha=0.05$.

Results
The achieved results have showed that homeless people assess their health condition as average or indicating a quality better than average. Despite that, these people indicate lower values of health behavior indicators than the average values of the normalization group. Proper eating habits, prophylactic behaviors, and health beneficial practices apply to homeless people much more rarely. Homeless people declare a sense of an external control over their health and a low sense of efficacy. People with a lower sense of own efficacy felt more socially alienated, whereas those with a higher sense of own efficacy were characterized by a higher positive mental attitude.

Conclusions
In terms of their health, homeless people require professional help of many trained specialists, such as for example nurses.

Keywords (in Polish):
zdrowie, samoocena zdrowia, korzystne dla zdrowia zachowania, zasoby osobiste, bezdomni.

Keywords (in English):
health, health self-assessment, health beneficial behaviors, personal resources, homeless.
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Samoocena zdrowia a zachowania zdrowotne bezdomnych

Authors (short)

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Introduction

Homelessness in Poland is an insufficiently understood mass phenomenon, which makes it difficult to define its size and internal diversification [1,2]. It constitutes one of the main social problems (European Typology of Homelessness and Housing Exclusion ETHOS). So far no unequivocal definition of homelessness has been created, due to its multi-aspect character which concerns social, psychological, and pedagogical problems, as well as social politics and economy [1,3]. It is most often associated with the lack of own shelter, a street style of life, deprivation of a unit's basic needs, or lack of social support within the family [4]. The European Federation of National Organisations Working with the Homeless (FENTSA) has developed a typology of homelessness and social exclusion (ETHOS) which constitutes an example of a universal concept definition and operational typology [1,3,5-7]. Poland allows homeless people to take advantage of temporary health benefits financed from the budget by an administrative decision of a local government [8,9].

The phenomenon of homelessness concerns many fields of a person's functioning, such as: psychological, health, social-living, housing, social, or family. Due to the subject of the paper, it is important to focus on the psychological and health fields. The first one is related to such problems as: sense of a lower life quality, low self-esteem and self-efficacy, ineffective behaviors in terms of difficulties and crises, tendencies to locate control externally, lowered toleration to difficult situations and stress, no sense of being connected to the surrounding, issues resulting from addictions and co-addictions, domestic violence, and disorders of behavior, identity, or mental functions. The health sphere is related to such problems as a general bad health condition of the homeless, level of disability, level of addiction, and old age [4,7]. Long lasting living on the streets is related to significant malnutrition, lack of hygiene and sleep, increased emotional tension, rejection, loneliness, constant stress resulting from an uncertain future, and often hypothermia, which all constitute factors having an impact on the development of multiple diseases within this group of people, homeless people experience a higher risk of premature death in comparison to people from the general population [1,2,10]. Furthermore, they are more prone to such afflictions as contagious diseases (HIV, hepatitis type C, or tuberculosis), high blood pressure, diabetes, distortions of the bone-joint system, addictions, mental illnesses, as well as feet and skin diseases. Due to the specifics of this social group, homeless people possess a limited access to health benefits because of their financial barriers, mental illnesses, self-negligence, or a negative attitude towards the health system.

Health behaviors constitute one of the main terms of health and illness psychology. They are defined as actions undertaken for health related purposes or such which possess a documented impact on the health. Primary sources refer to them as: medical behaviors, health beneficial practices, prophylactic activities, promotional behaviors, and health behaviors. Literature divides health behaviors into supporting behaviors meaning positive, health beneficial ones, and disadvantageous ones - in other words negative, anti-health, or destructive [11-19].

Health self-assessment defines in what manner a unit assesses the capabilities of its body to function on a daily basis. WHO accepts self-assessment as one of the population's health indicators [19, 20]. It is important to emphasize that it plays a significant role in regulating behaviors [13]. Sources state that as the subjective health condition of a unit becomes worse, the lower the unit's activity is and it keeps less

contact with its surrounding. People with a higher self-assessment of their health are not only more active but also have more plans for the future, are more satisfied with their life situation, less discouraged by failures, and more convinced as to their efficacy [21-24].

As it is put by Dębski & Retowski [25], the problem of homelessness, set between the problems of the labor market, unemployment, poverty, political, social, and economic changes, and system transformations, undergoes a „scientific" and „non-scientific" renaissance. The authors of the article notice also the various images of homelessness appearing in the public debate, but also see the insufficiency of this term in academic teachings of medical professionals. Nurses willing to work in the environment of homeless people should possess professional knowledge not only in terms of medicine but also public health, law, philosophy, psychology, social rehabilitation education, psychotherapy, sociology, and anthropology [2]. Thanks to this they can answer the real needs of homeless people. Nurses and medical professionals should understand the health condition/profile (psycho-physical) of homeless people.

Aim

The goal of the paper was to analyze the convergence between the self-assessment of health condition and the personal resources (sense of own efficacy, locating control) as well as health behaviors of homeless people.

Materials and methods

A diagnostic survey, taking advantage of the survey poll technique and survey questionnaire tool, has been used to carry out the research. The empirical material has been collected with the use of standard tools: B. Bojarska, R. Pikuła, and K. Wrześniewski's Polish version of the Nottingham Health Profile (NHP), J. Juczyński's Health Behavior Inventory (IZZ), R. Schwarzer, M. Jerusalem, and Z. Juczyński's General Self-Efficacy Scale (GSES), K. A. Wallston, B. S. Wallston, and R. DeVellis's Multidimensional Health Locus of Control (MHLC) adapted by Z. Juczyński, as well as Charles Carver's Measuring Coping Strategies with Stress (Mini-COPE) adapted by Z. Juczyński and N. Ogińska-Bulik [27-30].

The Nottingham Health Profile (NHP) allows the possibility to subjectively assess the quality of life related to health. This tool includes 38 problems which people experience in their daily lives. Each problem is assigned to specific spheres of life/scales, which are: energy, pain, emotional reactions, sleep distortions, social alienation, and motor limitations. Additionally the questionnaire includes 7 questions concerning problems related to health in such fields as: work, household chores, social life, family life, sexual life, interests and hobbies, as well as free time. Answers „yes" and „no" have been included next to each statement and indicate the presence of a given problem or its lack at the moment of the research. The raw result for each of the scales/spheres of life is achieved individually by summing up the „yes" answers. The higher the result the more impaired a given function is, meaning a lower quality of life [26,30,31].

The Health Behavior Inventory (IZZ) is used to determine the general level of health beneficial behaviors and degree of 4 health behaviors: proper eating habits, prophylactic behaviors, health practices, and a positive mental attitude. IZZ includes 24 statements describing various types of behaviors related to health. With each statement the frequency of a given behavior should be determined on a 1 (almost never) to 5 (almost always) scale. The sum of all points results in a general intensity indicator concerning the health behaviors. The higher the score the more intense it is. The general indicator of health behaviors undergoes an interpretation characteristic for a standard ten scale. The intensity of health behavior categories is calculated individually by summing up points from statements in specific categories, dividing by

6, and then comparing with average values. IZZ possesses well developed norms which allow interpreting the achieved results. After transforming the raw results (sum of points achieved in the entire test) into a standard ten scale, it is possible to determine whether the general intensification of health beneficial behaviors is low: women - 1-4 sten (24-77 pts.), men – 1-4 sten (25-71 pts.), average: women – 5-6 sten (78-91 pts.), men – 5-6 sten (72- 86 pts.), or high: women – 7-10 sten (92-120 pts), men – 7-10 sten (87-120 pts.) [28].

The Multidimensional Health Locus of Control (MHLC) refers to the approach of R. M. Levenson who juxtaposed internally located control over health with an external one, differentiating them in terms of the impact of others and chance. The MHLC scale (versions A and B) includes 18 statements and concerns convictions in terms of generalized expectations within 3 dimensions of locating control: internal (control over my health depends on me), impact of others (my health is the result of actions of third parties), and chance (random factors are decisive in terms of my health). At the base of each scale there is the assumption that an internally located health control works in favor of health beneficial behaviors. A researched person determines his or her attitude towards the given statements with the use of a 1 (definitely do not agree) to 6 (definitely agree) scale. The range of results for each scale covers 6 to 36 points. The higher the score the stronger the conviction that a given result has an impact on the health [28].

The General Self-Efficacy Scale (GSES) measures the strength of a unit's general conviction as to the efficacy of handling difficult situations and obstacles. Thanks to the sense of own efficacy it is possible to predict actions in various fields of human activity, including undertaking health behaviors. GSES includes 10 statements for which the researched person provides answers by marking the correct number - 1 meaning „no", 2 meaning „probably no", 3 „probably yes", and 4 „yes". The sum of all points provides a general indicator for the sense of own efficacy (from 10 to 40 points). The raw result is calculated with the use of standard ten norms in which: 1-4 sten (10-24 pts.) is a low result, 5-6 sten (25-29 pts.) – average result, and 7-10 sten (30-40 pts.) – high result [28].

The research material has been collected between November 2016 and March 2017 at some the centers for the homeless. The research has been conducted in accordance with the requirements of the Declaration of Helsinki. Respondents have been informed about the purpose of the research, a guarantee of being anonymous, and the manner of using the achieved results. A permit from the head office has been granted, as well as that of the management of specific centers, and the research participants.

The following tests have been used: t-Student for one research sample when comparing the sample's mean with an accepted norm, t-Student (parametric) and Mann–Whitney U test (non-parametric) measuring the significance of differences between two groups, and Spearman's rho coefficient correlation analysis (non-parametric) verifying the relation between the variables. In each case the level of significance has been accepted as $\alpha=0.05$, exceeding which, depending on the assumed hypothesis, allowed to confirm or disprove it. When conducting statistical calculations the Statistica 12.5 statistical set has been used.

The research included 58 homeless people residing in support centers such as shelters, flophouses, or homes. Selecting the sample was purposeful. A group of women and men between the ages of 20 and 73 were included in the research. The largest group consisted in people between the ages of 61-70. Slightly less (24%) of the researched people were between 51 and 60. The smallest group (2%) consisted in people above the age of 70. The average age of the researched was 50. The largest group consisted in men. Most of the researched (66%) possessed primary education and basic vocational education, 28% secondary, and 7% higher. Most researched people were single (46%). The largest group (38%) consisted in people homeless for more than 10 years. The smallest group (9%) consisted in people who were homeless 4-6 years. Slightly more people (10%) were homeless for 6-10 years.

The researched people were also asked in the survey questionnaire about their current source of income. Those people most often took advantage of the help provided by social welfare (45%) while 21% possessed no source of income. 16% took advantage of an unemployment benefit, 12% pension/retirement money, 12% worked on a contract of mandate, and 7% undertook occasional works. Remuneration from working on a contract constituted the source of income for 5% and contract for specific work for 2% of the respondents. 3% lived by collecting recyclable materials, and 2% beggary. The vast majority (81%) possessed health insurance. A large percentage of the researched, as much as 43%, possessed also a disability degree certificate. A significant problem with the researched people consisted in addictions. They most often concerned nicotine, declared by 60% of the respondents. Slightly less people were addicted to alcohol (38%), psychoactive substances (5%), medicine (5%), and 22% of the respondents believed not to be addicted. It should be noticed that 28% of the respondents declared more than one addiction. The most often reported health related problems consisted in cardiovascular diseases (38%), disabilities (31%), diseases of the respiratory tract (22%), depression (19%), skin disorders and ulcerations, as well as epilepsy (14%), and diabetes (9%). The least problems (2%) among the respondents concerned amputating limbs, liver diseases, HIV/AIDS, and schizophrenia. 21% of the respondents did not report any illnesses.

Results

Analyzing the results of the Nottingham Health Profile (NPH) allowed to determine that in terms of 4 scales: „Pain", „Emotional reactions", „Sleep disorders", and „Motor limitations" most respondents achieved significantly lower results indicating a lower impairment of a given function, meaning a better quality of life. In case of 2 scales: "Energy" and „Social alienation" most respondents achieved average results. Therefore, it may be stated that the researched people had a sense of being socially alienated and possessing lover energy resources. The summary results have been presented in table 1.

Tab. 1. Results concerning the homeless' self-assessment of health in terms of NPH

NHP	N	Mean	Value range	Low (0-25% max)	Average (26-74% max)	High (75-100% max)
Energy	58	1.33	0-3	17	31	10
Pain	58	3.16	0-8	31	9	18
Emotional reactions	58	2.83	0-9	35	14	9
Sleep distortions	58	2.10	0-5	26	22	10
Social alienation	58	1.79	0-5	23	26	9
Motor limitations	58	2.26	0-8	35	15	8

A standardized analysis of the IZZ with the use of the t-Student test allowed to determine that homeless people presented significantly lower values in terms of general health behaviors, as well as in the case of sub-scales concerning proper eating habits, prophylactic behaviors, and health beneficial practices, than the average results of the normalization group (table 2).

Tab. 2. Health behaviors of the homeless in terms of IZZ

Dependent variable: Health behavior (IZZ)			
Scale	**Researched group:**	**Mean**	**p (significance)**
Health Behavior Indicator	Research group (N=58)	71.31	.001
	Normalization group	81.82	t(57)=-4.486
Proper eating habits	Research group (N=58)	2.55	.001
	Normalization group	3.22	t(57)=-4.954
Prophylactic behaviors	Research group (N=58)	3.11	.018
	Normalization group	3.24	t(57)=-2.442
Positive mental attitude	Research group (N=58)	3.29	*.059*
	Normalization group	3.52	*t(57)=-1.193*
Health practices	Research group (N=58)	2.93	.002
	Normalization group	3.32	t(57)=-3.212

significance level α=0.05

The conducted statistical analysis of the GSE scale with the use of the t-Student test for one sample indicated a variable difference - homeless people (M=28.98) showed a significantly lower sense of own efficacy (p=.011; t(57)=2.615) than the normalization group (M=27.82).

Due to the high percentage of people older than 36 among the respondents (83%), it has been decided that in terms of the Multidimensional Health Locus of Control (MHLC) only the results of these people will be taken into consideration. The analysis conducted with the use of the t-Student test for one sample has indicated the lack of statistically significant differences. People above the age of 36 have indicated slightly lower values in terms of „The impact of others" and „Chance" than the average values of the normalization group (table 3).

Tab. 3. The homeless' sense of own efficacy in terms of GSES

Dependent variable: Generalised self-efficacy (GSES)			
Scale	**Researched group:**	**Mean**	**p (significance)**
Generalised self-efficacy	Research group (N=58)	28.98	.011 t(57)=2.615
	Normalization group	27.82	

significance level α=0.05

The conducted analysis of Spearman's rho coefficient for the age and level of the health self-assessment scale, health beneficial behaviors, sense of own efficacy, and locating control over health have indicated statistically significant results - the older the people the higher the values achieved by respondents in terms of sub-scales: Energy (rho=0.30; p=0.02), Pain (rho=0.35; p=0.00), health beneficial behavior indicator (rho=0.27; p=0.03), positive mental attitudes (rho=0.32; p=0.01), health beneficial practices (rho=0.34; p=0.00), and the impact of others (rho=0.37; p=0.00). There is a significant correlation between the self-assessment of the health condition, health beneficial behaviors, locating the control over health, and the age of the respondents. The older the homeless people the lower the possessed energy resources, more frequently experienced pain, higher chance of undertaking health behaviors, more positive mental attitude, higher chance of undertaking health practices, and a higher conviction concerning the impact of other people on the health. In case of other sub-scales („Emotional reactions", „Sleep disorders", „Social alienation", and „Motor limitations"), proper eating habits prophylactic behaviors, sense of own efficacy, as well as locating control over health - „Internal control" and „Chance", no significant dependency concerning age has been determined.

The dependency analysis carried out with the use of the Mann–Whitney U test between the gender and other variables determined a statistically significant difference in only one case. Homeless women (M=3.09) presented a significantly higher intensification of health behaviors concerning proper eating habits (U=233.5; p=0.05) than men (M=2.33). Furthermore, the achieved result was very close to significance (α<0.1) in terms of the sense of efficacy - homeless women (M=7.0) achieved significantly higher values (U=242.0); p=0.065) in terms of the sense of own efficacy than men (M=6.02).

Analyzing Spearman's rho correlation concerning the sense of own efficacy and level of health self-assessment also indicated statistically significant results. As the sense of social alienation grew, the sense of own efficacy significantly decreased (rho=-0.259, p=0.05).

Furthermore, the higher the sense of own efficacy was, the more often the homeless people expressed a positive mental attitude in terms of health behaviors (rho=0.27; p=0.04). In order to analyze the relation between the level of locating control over health and the self-assessment of health concerning the homeless, non-parametric Spearman's rho correlation tests have been carried out – table 4.

Tab. 4. The homeless' sense of locating control over health in terms of MHLC

Dependent variable: Multidimensional Health Locus of Control (MHLC)			
Scale	**Researched group:**	**Mean**	**p (significance)**
I (Internal control)	Research group (N=47)	24.94	.946 t(46)=0.069
	Normalization group	24.87	
O "The impact of others"	Research group (N=47)	23.17	.802 t(46)=-0.252
	Normalization group	23.43	
Ch (Chance)	Research group (N=47)	20.34	.341 t(46)=-0.963
	Normalization group	21.05	

The analysis has indicated statistically significant results for pairs of scales: „Impact of others" and „Pain", „Impact of others" and „Motor limitations", as well as „Chance" and „Emotional reactions" which direction is presented by figures 2, 3, and 4. Homeless people who were convinced about the impact of other people on their health significantly more often experienced pain and stronger motor limitations. Whereas, people convinced that their health condition depends on chance significantly more often reacted to their life situation in an emotional manner.

The conducted Spearman's rho correlation analysis concerning the levels of locating control over health and the levels of health behavior scales indicated statistically significant results. As the level of internal control significantly rose, the tendency to undertake correct eating habits significantly grew (rho=0.28; p=0.03), as did the positive mental attitude of the responding homeless people (rho=0.26; p=0.04). As the conviction about the impact of others on health grew, the general indicator of health behaviors also increased (rho=0.35; p=0.01), as did the tendency to undertake prophylactic behaviors (rho=0.35; p=0.01), positive mental attitudes (rho=0.29; p=0.02), and executing health practices (rho=0.29; p=0.02).

Discussion

According to a report from executing actions in favor of the homeless and a national research of the number of homeless people, most homeless people resided in shelters, hostels, houses for the homeless, warming-up facilities, and night-shelters and for that reason the authors of the paper conducted the research in random institutional facilities for the homeless [6,32,33].

Own research allowed to characterize the research group. The research group consisted in homeless people among whom the largest group were men, single and divorced people, between the ages of 51-70 which is accordant with the results of the report from 2014 and the national research of the number of homeless people [32,33].

According to own research, the largest group consisted in people remaining homeless for more

than 10 years. Completely different results are presented in the summary concerning the research of the number of homeless people in the Lubuskie voivodeship, where the largest group consisted in people remaining homeless for less than 2 years. This result is significant in the case of an attempt to work with such people because according to Pawlik [4] a person in the homeless phase looses motivation to undertake attempts to escape homelessness and becomes dependent on the provided support. According to the achieved results of own research the most frequent source of income consisted in taking advantage of social welfare resources.

Diseases of the circulatory system, disability, and diseases of the respiratory system constitute the health related problems most often listed by the respondents. The reason behind this may be the fact that as many as 60% of the respondents, at the moment of the research, declared to be addicted to nicotine. Additionally, disability limits a unit's motor activity. According to many authors smoking tobacco constitutes one of the main factors impacting a sudden heart failure related death as well as significantly correlates with the socioeconomic status. In own research this dependency that people with a low social status are more prone to be addicted to nicotine has been confirmed, because as many as 66% of the researched people possessed primary or basic vocational education. Similar results have been achieved in a report from a research concerning homeless people conducted in Poznań on January 21st/22nd 2015, in which primary or vocational education was declared by 73% of the respondents.

The definite majority of researched people (81%) possessed health insurance. This result is similar to the result achieved in a report from the research concerning homeless people carried out in Poznań on January 21st/22nd 2015, in which health insurance was possessed by 78% of the respondents [33].

The researched people assessed their health condition as average or better than average. Similar results were achieved by Henwood, Lahey, Rhoades et al. [39]. Whereas, in the report from a research concerning homeless people conducted in Poznań on January 21st/22nd 2015, the research people assessed their condition as good [33].

Homeless people in own research expressed a lower intensification of health behaviors. Furthermore, it has been determined that women showed a tendency to more frequently follow proper eating habits. Source literature presents slightly different results according to which women achieve higher values for health behaviors in all 4 categories [34-36].

Furthermore a dependency has been determined, according to which older people more often undertook health behaviors, and showed a positive mental attitude. Interesting results have also been achieved in researches carried out among people in their senior years, in which it has been determined that they undertake more health behaviors than people in the middle of their adulthood. The reason for that may be the fact that the older a person is the more problems with health he or she experiences, and as a result takes better care of the health.

Whereas, an external sense of control over health determined limitations in executing health behaviors [37]. This may result from a lack of knowledge concerning health behavior among homeless people, most of which consist in people possessing poor education, and as it is shown by researches conducted by E. Grochans et al. [35], people with a lower vocational education are characterized by a lower intensification of health behaviors. Juczyński [27] refers to researches in which it has been determined that frequently engaging in prophylactic behaviors is connected with assigning a higher impact on own health to external control, whereas following daily health practices and eating habits - internal control.

Positive mental attitude is impacted both by an internal conviction as well as third parties. According to Bandury's theory the sense of efficacy constitutes a good indicator of health behaviors [12]. However, own work did not determine any significant correlations between own efficacy and health behaviors, apart from a positive mental attitude. In researches by Zadworna-Cieślak and Ogińska-Bulik

[36] a positive mental attitude was related to life optimism. Authors point the attention to the fact that psychological conditionings are especially important in terms of undertaking health behaviors. A relation between the gender of the researched people and the sense of own efficacy has been determined in the course of own research. Different results have been achieved by Juczyński [27], who did not determine any statistical differences in terms of the sense of own efficacy between the researched genders.

The sense of own efficacy plays a significant role for example in the case of carrying out health education, during which one of the goals should be convincing the recipients that they are able to change their behavior and possesses a new one. Without this, conducting any education seems not to have any sense [12,37,38]. Researched people were characterized by a low sense of own efficacy and high addiction to nicotine. The low sense of own efficacy may be impacted by the fact that the vast majority of researched people remained homeless for more than 10 years [4].

In source literature it is much easier to find researches concerning health behaviors and personal resources conducted among nurses, students, or patients with a specific disease. In the daily work of nurses, homeless people are also included among their diverse patients. In order to be able to provide the best nursing care in light of the European WHO Strategy for educating nurses and midwives, it becomes necessary to approach the patient and the problem in a holistic manner, with the sole researches and their results emphasizing the necessity to introduce changes, for example in terms of academic internships [2,25,41].

Conclusions

1. Most homeless people assessed their health condition as average, or better than the average quality of life, significantly less often followed proper eating habits, prophylactic behaviors, or health practices.
2. People with a lower sense of own efficacy felt more socially alienated, whereas those with a higher sense of own efficacy were characterized by a higher positive mental attitude.
3. People convinced that their health depends on them, more often followed proper eating habits and showed a positive mental attitude. People for which health was a result of the actions of other people more often undertook prophylactic actions, health practices, and showed a positive mental attitude.
4. In terms of own health, homeless people require professional help from may professionally trained specialists, such as nurses and social caregivers.

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